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Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Admission is entirely on a voluntary basis and a person cannot be accepted on court order or legal commitment. The Center cannot accept persons who have any court hearing or legal action pending which would interfere with or curtail their treatment program.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770 or 985-4420). All appointments are confirmed by mail. They should be made through a physician or other professional person in the prospective patient's community.

3. Patients are expected to be sober on admission, and the Center will not admit a person if intoxication impairs his functioning. The Center does not have nursing or hospital facilities to treat acute intoxication.

4. A written report of a recent physical examination by a licensed physician must be presented upon admission. The patient's physical and mental condition must be good enough to enable him to participate in the treatment program, walk up and down stairs, etc. The Center does not have hospital beds or nursing staff for the treatment of serious physical or mental disorders.

5. A fee of $7.00 per day is charged for the four weeks of treatment. This may be paid by cash or check at the time of admission, or by an agreement signed by the patient at the time of admission — promising to pay the full sum at some time after discharge.

If a person is indigent he may obtain a letter stating this fact from his local county welfare agency, and upon presentation of this letter at the time of admission the request for payment will be deferred.

The Center does not refuse to admit any person because of lack of money, but feels that patients having treatment should take responsibility for the cost of the services if they are able to pay at the time of admission or later.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

Patients are admitted to the Center five days a week, Monday through Friday, between 9:00 a.m. and 12:00 noon and 1:00 p.m. and 5:00 p.m. by appointments as described above.

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Whereas methods of alcohol education are derived from standard classroom procedures, its philosophy stems from preventive medicine.

ALCOHOL OR ALCOHOLISM — THE EDUCATOR'S DILEMMA

BY WILLIAM HALES, M.P.H.

This article is based on a paper presented by the author during the 1968 Summer School of Alcoholic Studies at the University of North Carolina in Chapel Hill. Mr. Hales, associate director of the Charlotte Council on Alcoholism, is a health educator by profession and holds a master of arts degree in public health. He is also the current president of the Alcoholism Program of N. C.

EDUCATION in the field of alcoholism is in reality not too different from education in any health field. Only the techniques must be altered to deal with the unique problems created as a result of a condition with physical, emotional and social manifestations as those presented by alcoholism. Because of its complexity, it is extremely important that we have a relatively clear understanding of education, alcohol education, alcoholism education, what it is, how to do it, and how it differs. To put it more simply, we must ourselves know what we are doing and why we are doing it. If, for instance, we are considering the question of primary prevention of alcoholism as the controlling element, and I agree with that thesis entirely, then we are talking about both alcohol and alcoholism education.

Frankly, I am somewhat hesitant to make a distinction between the two since both of them are related to the growth of children and their ability later to function in society as an adult. That success in adult life is based on the experiences of childhood is a generalization supported by ample evidence. Whether we are discussing alcoholism or alcohol problems of other origin, from an educational standpoint none of it makes sense except in terms of the emotional and social learning of the individuals involved.

Those who make a distinction between these two types of education have in mind two areas of knowledge that are related but different in their focus. They also see the job of education as communicating; that is, telling young people what they need to know about a particular subject.

There is little about this approach to quarrel with—provided it is directed to an older high school audience, one without too many emotonal blocks on the subject, which lacks its

own established set of biases or has not been conditioned to the biases of an older generation. Such an audience may be hard to find, since the roots of drinking and the vulnerability to alcoholism become established much earlier than high school. Experimental social drinking even is apt to begin before a youngster enters high school.

Consequently, if we are talking about academic and intellectual learning, the distinction between alcohol education and alcoholism education is proper and necessary. If, on the other hand, we are considering the more pervasive and enduring aspect of developing emotional maturity in young people, the distinction is not valid.

Both kinds of problems—emotional immaturity as well as alcoholism—appear to have their roots in childhood. Many prominent men in this field have expressed this point in many ways. Dr. Gordon Bell summarizes it with these words, "The prevention of a way of life involving dependence on alcohol puts the whole emphasis on the normal healthy growth of the child." The late Raymond McCarthy said, "While there is no single indisputable cause of alcoholism, it is a pretty good bet that a mature, balanced personality has pretty good insurance against ever becoming an alcoholic." Dr. Richard Bates of Michigan states very simply, "I have never in my years of experience seen an emotionally mature person who was an alcoholic."

Since work in the area of healthy development of children possibly prevents other dysfunctions as well as alcohol problems and alcoholism, some people would not call it alcohol or alcoholism education. For instance, it has been described as "bootleg mental health." What ever the label, this area of work is pertinent to prevention of alcohol problems and alcoholism as we have seen.

Some people believe our educational efforts, at least initially, should be directed toward the opinion formers of our community. Certainly we cannot ignore the stigma associated with alcoholism or the fact that it is still our most neglected health problem. Indeed, the fact that it has only comparatively recently been recognized as a health problem, and the fact that it has long been believed to be a behavioral problem to be treated with punishment, stigma, or overtolerance has made it an underground disease that most communities find easy to sweep under the rug—at least until the rug becomes bigger and more objectional than what they are sweeping under it.

Possession of information does not insure assimilation.

If we go along with this idea, then there are some principles involved in community education that we should be aware of. For instance, we need to take advantage of the "teachable moment" or that moment when maximum action can be realized. In other words, we need to strike while or when the iron is hot. We have to be sensitive to the climate of our communities and exert our educational efforts at opportune times. We also need to keep in mind that ego protection allows people to believe only what they want to perceive. Mere possession of information does not guarantee that the individual will respond to or apply the information.

Even though the *need* for community education is strikingly apparent,

its relation to prevention of alcoholism is not. Perhaps, in order to bring the relevance of community education to prevention in focus, it might be well at this point to start over and show the correlation between preventive teaching or education and preventive medicine.

One point of clarification is that whereas *methods* of alcohol education are derived from standard classroom procedures, its *philosophy* stems from preventive medicine. Furthermore, in the minds of many people the term "alcohol education" is synonymous with "alcohol education in the schools." In translating from the schools to the community, we have failed to make it clear that alcohol education in the schools is part of alcohol education in the community. Both are part of community education and preventive teaching but they have their different focuses.

If there is such a thing as prevention of alcoholism, other than the catch-all mental health and child development practices already mentioned, it is intervention at the point of recognition of the early signs. Education to bring this about is more the focus of traditional community or public education.

In view of the fact that we are pretty well convinced that the alcoholic was rendered vulnerable by early childhood experiences, we can readily see that the teacher's concern for keeping children healthy and helping them to grow, mature and function well is a direct contribution to the field of prevention. The relation of the focus of public education to prevention is more obscure. As Dr. H. B. Krouse said in his book *Problem Drinking and Alcoholism,* "Prevention and preventive medicine are broad terms in various usage, covering the range from prevention of death to the final stages of a full blown disease on to prevention of the earliest signs. It is the latter which is the ultimate achievement. It carries with it the assumption that the disease is an entity with recognizable signs in its earliest stages. At present we recognize alcoholism only when the illness is far advanced, or in the crisis stage."

Prevention of alcoholism by intervention at the point of recognition of early signs is theoretically sound but virtually nonexistent. Its lack is one of the greatest deterrents to alcoholism control and one of the greatest challenges to education. Part of the difficulty in achieving prevention by this means lies in the fact that to the opinion formers of the community, the professional people and others whose jobs bring them in contact with alcoholism and alcohol problems, prevention is secondary to the immediate, urgent and important day by day goals for which they are working.

What are some of the other more definable distinctions between alcohol education, education to prevent alcoholism, and education about alcoholism?

First, alcohol education is the broader term which encompasses the others. As presently practiced in the schools, alcohol education is more than an academic program. It includes the presentation of scientific information about alcohol, its use as a beverage and its effects on individuals and society, but it is also aimed at developing understanding of the reasons for cultural diversity and cultural conflict about the use of alcohol. It seeks also to prepare the student to develop his own attitude toward alcohol, to make his own personal decision concerning alcohol use, and to develop a sense of responsibility, both for himself and for oth-

(Continued on page 6)

In an effort to gain a little insight into the drying out process, I resolved to refrain from smoking one week end.

To Each His Own Addiction

BY JOHN L. PIETERS

This article is a condensation of "The Alcoholic and I" from the *Michigan Alcohol Education Journal* as reprinted in *Focus,* of the Washington State Department of *Health.*

AS a beginning Probation Officer, I, like others who consider themselves well educated and well read, "knew" a great deal about alcoholism I knew it to be a disease, I knew that for the alcoholic one drink is too many and a thousand not nearly enough. I knew these and many other facts, but the underlying emotional factors did not, for me, assume the aspect of reality.

I did not appreciate the emotional irregularities which eventually form the foundation for the jug-shaped house in which the alcoholic lives out his loneliness.

Frankly, my "knowledge" was a serious handicap. Before I could learn facts I had to unlearn many fictions, such as my assumption that the alcoholic is a bum who refuses to resist.

As the truth began to penetrate, it brought with it wholesome attitudes toward those of my probationers who are alcoholics. Suddenly these men whom I had regarded as needing some backbone, men who must be treated with firmness bordering on the punitive, became men who were no different from the probationers with heart trouble. Their disorders differed, but the men were simply men with problems, men who needed understanding, who must be encouraged to seek all available help in combatting a specific ailment.

In an effort to gain some little insight into the drying out process, I resolved to abstain from smoking through one week end, beginning with my awakening on Saturday morning.

Since the alcoholic's progress or regression is closely watched by his family, I attempted to simulate his situation by telling my wife I would not smoke a cigarette before Monday morning. We discussed my purpose at breakfast and, when my wife pointed out that I had unconsciously reached for a cigarette, I began to regret my noble decision.

As the day wore on I experienced in a small way something akin to the early symptoms of alcoholism. After only an hour I was tempted to leave the house and sneak a smoke.

I was certainly preoccupied with the thought of tobacco, even to the extent of seriously considering the merits of chewing. Candy, food, coffee could not begin to satisfy my appetite. Trying to divert my attention by watching television, by reading, and by work accomplished nothing.

During the moments I could lock thoughts of tobacco out of my mind, I found myself reaching unconsciously for the weed.

In the early hours of abstinence I had reached a decision which I now recognize as another of the problems of the alcoholic, the alibi. I had decided that it was not necessary to wait until Monday morning to smoke, convinced I would have made my point by Saturday evening.

Having made that decision I became sympathetic with the drink gulper, thinking of the day's first cigarette, now only six or seven hours away. How enjoyable it would be. What would it be like to inhale directly through a cigarette without diluting the smoke with air?

The afternoon was young when my wife began suggesting that I not wait until six o'clock for a cigarette. By this time she genuinely resented my complaints and faultfinding. What had begun as a good - natured experiment was not furnishing many laughs.

I remember that, as a youngster, December 24 was always the longest day of the year. Compared with that Saturday, the Christmas Eves of bygone years flew by.

Although it seemed at times that the clocks had been thrown into reverse, six o'clock—and my cigarette—finally arrived.

The first two or three puffs were delightful.

Then came another symptom — remorse. It was humiliating to think that shredded vegetable matter wrapped in a paper was a bigger man than I. It was no longer easy to dismiss the alcoholic as a weak-willed individual.

ers, in regard to drinking alcoholic beverages. The application of mental health principles is essential, since the academic program would be of little value if directed to an emotionally disturbed child. This type of alcohol education directed to the community at large constitutes re-education, an infinitely more difficult and painstaking undertaking.

What about education to prevent alcoholism? This, too, is a most difficult task since the causes of alcoholism are not specifically known and certainly cannot be confined to a single factor. However, the suspected multi-faceted causes of alcoholism that we read about in the literature suggest a corresponding multi-faceted approach to prevention. Such an approach, in addition to application of mental health principles and child development practices and intervention at the point of recognition of early signs, would include research, and, as some authorities insist, development of culturally acceptable controls which will minimize drunkenness as an approach to meeting social and psychological stresses.

In view of the limitations of our present knowledge about alcoholism, others have expressed less optimism for the possibilities of prevention. Some authorities contend that ultimate prevention of alcoholism is an impossible task; that is, as long as we have people, we will have alcoholism. For instance, Dr. Seldon Bacon of Rutgers University has stated, "If and when we solve the problems of alcoholism, we will have solved so many problems of far greater human importance that we will have forgotten that alcoholism was our ultimate goal initially."

The fact is that much of what actually goes on in the name of education to *prevent* alcoholism is in reality education *about* alcoholism.

The multi-faceted causes

What is the difference? The former has been discussed. The latter, education about alcoholism, is presumed to be preventive; however this type of education merely strives to acquaint people—whether they are interested or not—with the causes of alcoholism, its progress and ravages, its treatment and treatment outcomes or rehabilitation. Certainly, education about alcoholism is needed in our society, but its contribution to *primary* prevention is anybody's guess. To my mind it is more related to treatment than to prevention.

At this point, however, I would like to share with you twelve needs of prevention and alcoholism control as defined by Ernest Shepherd, chief of the Alcohol and Drug Dependent Division of the Connecticut Department of Mental Health: 1) Recognize that some persons cannot drink; 2) Police trained to be aware of the possibility of other conditions; 3) Our courts designed to help as well as to mete out punishment; 4) Physicians trained to treat alcoholism as well as the physical abnormality; 5) Our hospitals to admit the person with alchoholism as part of its routine medical service; 6) Ministers to understand all factors involved; 7) Social agencies to work with alcoholism; 8) Health departments to integrate alcoholism in its total program of education and services; 9) Business and industry to detect early alcoholism, before the problem reaches the point that unemployment becomes necessary; 10) Schools to teach without attempting to indoctrinate into any particular philosophy; 11) Rehabilitation services at the local level where all concerned can become involved; and 12) Or-

ganized groups to take on projects. Each need, as you can see, in itself requires a tremendous educational effort.

To this list I would add a thirteenth need: churches that create a moral climate within which an individual with an emotional problem such as alcoholism can find warmth, understanding and peace. A Presbyterian minister expressed this thought when he said, "Our churches should become hospitals for sinners rather than hotels for saints."

In educating for alcoholism control, we must keep in mind the various attitudes in our society toward alcoholism. In dealing with the whole question of alcohol, its use and abuse, and alcoholism, we are addressing not one society but rather we are talking to at least five different societies:

The first may be classified as the anti-drinking society. This society is composed of people who believe that the use of alcohol by anyone is wrong; it is a sin.

The second, a non-drinking society, is composed of person who, because of their personal beliefs, choose not to drink but have no objection if others do so long as it doesn't interfere with their life.

The third society may be described as the social drinking society. It is composed of those persons who use a drink of alcoholic beverage much the same as someone else would use a coke or a cup of coffee. This society, or the persons in it, generally limit themselves to one or two drinks at the most and never become intoxicated or very rarely, if ever, reach any degree of intoxication.

The fourth society may be classified as the drunk society. It is composed of people who plan to get drunk and go ahead and do it. In other words, they purchase a bottle and go to a party or what have you for the express purpose of becoming intoxicated. This they plan to do and they do it by their own choice and by their own design. This is the type of person that you may find behind you at a football game on Saturday afternoon who, by the end of the first half, not only doesn't know who is playing but doesn't care.

The fifth society is the society of persons with alcoholism; that is, those persons who use alcohol by necessity, not by choice; who drink not because they want to, but because they have to.

In conclusion, let me say that alcohol education which is truly preventive takes place in the child-centered school which has a life-centered curriculum. We have only to look at the large numbers of our people who make use of alcohol to facilitate their interpersonal relations, their careers, their marital relations and to ease psychological pain to begin to appreciate the extent of social and emotional inadequacies prevalent in our society. Alcohol, regrettably, is too often the tragic answer to atrocious mental health and child rearing practices. The challenge of education and alcoholism control is simply this: Can we provide the opportunity and environment for adequate character and personality development that will lead to constructive solutions of human problems? Can we so pattern human growth that there will be no need to resort to alcohol or any other chemical substitute to help our people face the realities of life?

Alcoholism: An Inventory

BY DAVID J. PITTMAN, PH.D.

What each community and state must have in order to solve its alcoholism problem is an identifiable focus of responsibility.

THE prevalence of alcoholism in America makes this one of the country's major medical and social problems. Gross estimates indicate that of the approximately 80 million users of alcoholic beverages in America, around 6 million are excessive drinkers and may be classified as alcoholics.

The problem of alcoholism is so excessive, with our country having the second highest rate in the world, that current efforts at the federal, state, and municipal level do not represent a major attack on this problem. According to the Department of Health, Education, and Welfare, alcoholism is one of the four major health problems in the United States with approximately 200,000 new cases occurring yearly. Furthermore, alcoholism costs American business around 2 billion dollars yearly by its effects on at least 2 million workers —from the union member on the assembly line to the corporation tycoon.

In fact in a recent report by the former Secretary of Health, Education, and Welfare, John Gardner, he stated, "No other national health problem has been so seriously neglected as alcoholism." The National Center for the Prevention and Control of Alcoholism in the National Institute of Mental Health is an excellent start, but it is under-supported in terms of financial resources allocated to its activities. The recently introduced Alcoholism Rehabilitation Act in the 90th Congress by the Johnson Administration in 1968 is a major sign of increasing governmental awareness.

Governmental Programs

The United States remains one of the few countries in the Western world without an enacted legislative program of alcoholism control at the national level. However, the record of the American states and municipalities in the area of legislatively establishing alcoholism programs is much better, although at times the financial resources allocated are deficient in many governmental jurisdictions. National alcoholism programs

(David J. Pittman, Ph.D., a transplanted eastern North Carolinian, is regarded as one of the world's leading authorities on alcoholism. His knowledge of alcoholism and alcoholism services internationally is unique among Americans working in the field. In recent years he has made twenty trips to Yugoslavia, Poland and other nations, some as consultant to alcoholism projects sponsored by Social and Rehabilitation Services of the Department of Health, Education and Welfare. In 1966-67 he was recipient of a special fellowship from the National Institute of Mental Health for research and training in The Netherlands and United Kingdom. Otherwise, he has distinguished himself as a social scientist, an editor and an author.)

This article is based on an address the author gave at the annual meeting of the Pitt County Alcohol Information and Service Center, Greenville, N. C., April 1, 1968. Dr. Pittman is a professor of sociology and director of the Social Science Institute of Washington University, Saint Louis, Missouri.

now exist in The Netherlands, Sweden, Finland, Poland, Czechoslovakia, the Soviet Union, France, Norway, Bulgaria, Hungary, and other countries. To understand the lack of American attention to alcoholism and its concomitant problems, we must briefly focus on the historical background of this health problem in the United States.

Historical Background—Prohibition

The idea—to use the current slogan of the National Council on Alcoholism—that "Alcoholism is a disease, it is treatable and beatable" is not new. Prior to the enactment of Prohibition in the United States in 1920, it was not rare to read and hear the opinion that inebriety or chronic drunkenness was an illness. For example, that early social work pioneer, Mary Richmond, in her classic book, *Social Diagnosis,* termed inebriety, or in current parlance, alcoholism, an illness which needed treatment.

The Prohibitionistic ideology, an outgrowth of the Northern and Western European Protestant ethic which was transplanted to the American industrial scene coupled with social reform aspirations, won a major victory with the passage of the 18th Amendment to the Constitution in 1920. The new millennium had arrived. Many social reformers felt that excessive drinking was one of the major causes of poverty and degradation in our society. To them the cure for deplorable social conditions was simple; namely, abolish drinking and the miserable social conditions would disappear. Certain religious zealots believed in a worldly asceticism in which such pleasures as dancing, card playing, horseracing, smoking, and drinking were to be avoided. Oversimplified, to these individuals, there were only two conditions in reference to alcoholic beverages—abstinence and drunkenness. Social drinking was nonexistent to them. The approach to the excessive drinker in this period was basically moralistic, and his condition was explained as self-engendered. The preferred mode of treatment, if we may stretch the meaning of that word, was one of exhortation and conversion. Thus in the 1920's the approach to the alcoholic in the United States, and to a certain extent in those Scandinavian countries which also tried the "Noble Experiment," became inextricably bound to a moralistic, non-scientific, and pseudo-religious approach. Alcoholism, for all practical purposes no longer was in the province of the basic and clinical sciences; it was not a concern for medicine, sociology, social work, and psychology.

As we all know, Prohibition ended with its repeal by the 21st Amendment to the Constitution in 1933 at the height of the Great Depression. Poverty still existed in the society,

A Community Problem

alcoholics were still with us, and people were still drinking. The old ideology—officially approved with the passage of Prohibition—had collapsed, but the moralistic and religious foundations still remained anchored in vast sections of the society, as they still remain in 1968, although receding.

A New Ideology: Science and Disease

Surveying the wreckage of the Prohibitionistic ideology in the 1930's is similar to the carnage seen on the battlefield — destroyed hypotheses and concepts, shattered interpretations of the causes of society's ills, and battered moralistic and religious ideals. Moreover, because of the heavy involvement of governmental, especially federal, resources in the enforcement of Prohibition, these same bodies were reluctant to become re-involved in the problems of alcohol and alcoholism.

But social and personal conditions such as skid-row denizens and alcoholics needed ideologies to explain them even as ideologies need problems to justify their *weltanschauung*. The buds of the new ideology—that alcoholism was a disease, that it was amenable to treatment, and that scientific study would bring eventual understanding and perhaps prevention — began to sprout from the wreckage of Prohibition. The initial building blocks for this new ideology which we will label the "science and disease" approach were set in place by the pioneers in alcoholism who labored in the vineyards of stigma, low esteem and status, and rejection attached to the alcoholic. The new "science and disease" ideology became formalized in organizations such as Alcoholics Anonymous in 1935, the National Council on Alcoholism, the Yale and later the Rutgers Center of Alcohol Studies, and the North American Association of Alcoholism Programs, and resulted in the creation of scores of state, provincial, and municipal alcoholism programs beginning with the Oregon state program in 1943. In the next decade the American Medical Association and the American Hospital Association issued statements in support of the new ideology.

Beginning with the Oregon program, American states and municipalities have been in the forefront of organizing governmental activities for alcoholism treatment, research, education, and prevention. As of today, 45 states and the District of Columbia have identifiable funded alcoholism units at the state level. Alaska is in the process of forming a state unit, Oklahoma had a Governor's Committee on Alcoholism in operation, but a previously existing program in Kansas has ceased to be a viable unit although attempts are currently being made to revive it. Only Delaware is marked by the absence of current or past statewide alcoholism activities.

Governmental Involvement

Despite the pattern of organization, the American states have shown a strong awareness of the need for governmental involvement in alcoholism. The same generalization is true for many municipal governments. Municipal alcoholism programs, whether anchored in local health departments, local hospitals, special commissions, boards of county commissioners, in police, court, or correctional authorities, have a significant role to play in alcoholism control activities. For example, in developing new patterns of care for the public or "revolving-door" alcoholic, almost all innovations in treatment have occurred at the local municipal level — specifically in

"court honor classes" for alcoholics in Des Moines and Denver, in short-term correctional programs in Portland, Oregon, and Atlanta, in the police detoxification center procedures in St. Louis, Washington, and Des Moines, in poverty programs in Boston, and in municipal hospital care programs in Boston and Cincinnati.

In short, in the last twenty-five years almost all governmental activities in the field of alcoholism have occurred at the state and municipal level. It is a frequent criticism today that state and local governments have ignored their responsibilities and have abdicated them to the federal level. This is blatantly untrue for the field of alcoholism control where the federal government had been minimally involved until 1966.

status degrading process of arrest, jailing, and re-arrest, which in an earlier work I termed the "revolving-door process."

It is indeed a source of pride to note that the first Detoxification Center in North America to systematically remove chronic alcoholics (whose only offense is public intoxication) from the jails is in St. Louis, Misisouri. The Detoxification Center is an undertaking of the St. Louis Metropolitan Police Department, along with the cooperation of the Sisters of St. Mary's and the Social Science Institute of Washington University, which I head. This Detoxification Center in St. Louis in the 17 months of its operation has become a model for the whole nation, and the results thus far obtained have far surpassed our expectations—

P.S. Since April both Houses of Congress have passed the "Alcoholism Rehabilitation Act," and the U. S. Supreme Court, in the Powell v. Texas case, ruled that chronic alcoholics may be jailed for public intoxication. While disappointing, it has been pointed out that the Supreme Court's decision by no means prohibits the use of treatment by localities in handling drunk cases and, since it was split, will likely result in another ruling on another case in the future. Editor.

Court Decisions and Alcoholism

Recent United States Courts of Appeals' decisions in Virginia and the District of Columbia have ruled that chronic alcoholism may be used as a positive defense to the charge of public intoxication. This change in legal interpretation must be placed against the backdrop of the fact that in 1966 about one-third of all arrests made by American police were for public intoxication violations.

New medical and social approaches to public drunkenness will have to be mounted in American communities. As the President's Commission of Law Enforcement and Administration of Justice, to which I served as a consultant, recommended, communities should establish civil detoxification centers to remove the chronic drunkenness offenders from the approximately 20 per cent of the chronic inebriates were abstinent when interviewed in the community three months after treatment. And this was achieved with a group considered helpless and hopeless. The "drunk tank," hopefully, has been permanently relegated to the past in St. Louis.

North Carolina, and I am talking about my home state now, has been one of the more punitive states in regard to public intoxication, having a statute which allowed a prison sentence up to two years for a person with three convictions in one year. The Driver decision, which is applicable to North Carolina, provided the pressure for liberalizing this statute in the 1967 Legislature.

In October, 1967, the St. Louis Board of Aldermen unanimously

passed a new statute governing public intoxication in our city without any court pressure being needed. The essence of the new statute is that chronic alcoholism is a positive defense to a charge of public intoxication. However, very few cases of public intoxication involving chronic alcoholics find their way to the municipal court any more as they are handled in the major medical facility (the Detoxification Center). This thirty-bed facility is supported in a cooperative endeavor of federal, state, and local agencies. The federal government, through the Office of Law Enforcement Assistance in the Department of Justice, provided the original grant; The Missouri State Legislature in its recent special session just concluded in March, 1968, appropriated $150,000 for the partial support of detoxification centers in our major urban centers of St. Louis, Kansas City, and Springfield; and the St. Louis Board of Police Commissioners has appropriated municipal funds with the approval of the Board of Apportionment and Estimate. The Detoxification Center now handles approximately 80 per cent of all "drunk on street" cases in St. Louis and graphically demonstrates what a community can do when it is willing to move on this major problem. The goal of our state and municipal agencies is the total removal of chronic alcoholics, whose only offense is public intoxication, from the jail cells of America. I would like to note that in Missouri the support of the press, television, radio, and community organizations has been completely behind these new actions to remove chronic alcoholics from the judicial process to the medical, rehabilitative, and social context.

On March 7, 1968, the Supreme Court of the United States heard arguments on the Powell vs. Texas case, and the Court has been asked to rule on the constitutionality of the public intoxication statute's use in cases involving chronic alcoholics. It is expected that the Court will rule that chronic alcoholism is a positive defense to charges of public intoxication and that these individuals are not to be incarcerated but must receive medical and social treatment. Thus, there will be a crisis in treatment resources unless bold and imaginative steps are taken by local communities now.

But the tragedy is that the implementation of court decisions with new programs and facilities has been so difficult to obtain, and individuals are still dying in the jail cells of America from chronic alcoholism. In view of this, and when our hospitals refuse admission to alcoholics, we cannot claim to provide the "best medical care" that pride in American leadership sometimes leads us to do.

Focus of Responsibility

What each community and state must have in order to solve its alcoholism problem is an identifiable locus or focus of responsibility. The responsible agency must be concerned with providing education, information, referral, and counseling services in the area of alcoholism and alcohol problems, and have as its function working in coordination with other interested groups, such as the tuberculosis society, medical society, mental health agency and clinic, Alcoholics Anonymous, Al-Anon, health and welfare departments, police departments, courts, hospitals, specialized treatment facilities, and so forth.

Federal Government Action

But for local and state initiative to be successful in combatting this

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VOL. 18, NO. 1 INVENTORY JULY-SEPTEMBER, 1968

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

"We all recognize the need for a team approach; then we promptly proceed to work in our own little corner . . ."

Alcoholism And The Helping Professions

BY RICHARD SILVER, M.S.W.

THERE is no reason why we cannot treat alcoholism even though its exact cause or causes have not been identified. Many illnesses with unknown etiology are treated successfully without causing undue frustration to the helping professions. Without the slightest hesitation, psychiatrists, psychologists, and social workers deal every day with emotional problems of unknown or, at least, poorly established origin.

It has been proved conclusively that alcoholics can be treated successfully. Alcoholics, themselves, found a pathway to their recovery at a time when practically all professionals considered them hopeless and preferred to devote their energies and efforts to more socially acceptable illnesses.

We might concentrate on evaluating the nature of the problem at hand, rather than on the diagnostic label per se. If the individual's drinking is such that it seriously interferes with his ability to get along with himself and others, then something has to be done about it.

It makes no real difference what caused the pathological drinking. Until this particular pathology—the drinking—is dealt with, none of the problems he may present can be alleviated.

Nevertheless, most professionals concentrate on the alcoholic's so-called underlying problems and disregard his drinking.

As a result, the patient often fails to improve and is described as "poorly motivated" or "not amenable to treatment."

Several years ago, Harry M. Tiebout, M. D., in an address to the American Psychiatric Association, had this to say about the question of treating the underlying disturbance:

This article was adapted from a paper read at a conference on alcoholism—*Alcoholism: A Special Problem in Mental Health.* It is reprinted from *Focus,* a publication of the Washington State Department of Health. The author, Richard Silver, M.S.W., is executive director of the Seattle Committee on Alcoholism.

While therapy directed toward the cause of a condition is ideal, total neglect of the symptom may result in ineffective therapy. The symptom itself may assume disease proportions. This may be illustrated by analogy with fever.

Nowadays no one treats a fever. One looks for the causative agent and treats for that, knowing that the fever will subside if its cause can be eradicated. Occasionally, however, the fever gets out of hand and becomes in and of itself a threat to the patient's life. At that point, regardless of cause, the fever itself must be reduced below the level where it threatens life. In the beginning, the fever could be considered a symptom and could be safely ignored as an object of therapy. It may, however, overwhelm the clinical picture, and when it does it must become the aim of treatment if the patient is to survive. To continue to focus on the cause in the face of the immediate threat to life would be therapeutic folly.

Another analogy may be cited. Irritation may produce some form of cancer; or, to put it differently, cancer may be a reaction to or a symptom of irritation of some sort. Once the cancer process has started, however, removal of the irritation does not stay it. The abnormal growth proceeds unchecked and it must be attacked directly. In other words, what started as a symptomatic response finally assumes disease significance and we then treat it as an independent illness.

The same thinking is valid for alcoholism. It, too, is a symptom which has taken on disease significance. Though starting as a symptom of underlying factors, it gains momentum until it gets out of hand and becomes a disease in itself. To insist on treatment of the original causes is like focusing upon the cause of the life-threatening fever or upon the irritation leading to cancer. The cause and the origins are irrelevant to the immediate danger.

Alcoholism is not purely and simply a mental health problem. There are emotional components in many alcoholics, and, as such, their alcoholism is related to mental health. Alcoholism, however, has medical and spiritual aspects, too, which become apparent as the illness progresses.

Rehabilitation in various areas

In alcoholism the patient may

may be necessary rather than treatment per se. If alcoholism is viewed as a traditional psychiatric problem then we fall back into the dilemma of searching for the underlying emotional disturbance while the patient dies of alcoholism.

Early recognition of drinking problems is the exception, rather than the rule. We usually do not recognize alcoholism until it has become so obvious that it can no longer be overlooked.

We share the conflicting attitudes of the general public. We usually don't ask questions about a person's drinking anymore than we inquire into his sex life.

We believe that almost everyone drinks as a matter of choice and can control his drinking.

We fail to recognize the difference between normal, social drinking and pathological drinking.

We cannot believe that a well-dressed, intelligent, and likeable colleague, friend, or neighbor could be an alcoholic.

It is emotionally more comfortable to view alcoholics as skid-road characters, who are completely unlike us. This removes them from our area of uneasiness and concern.

Morris E. Chafetz, M. D., and others in a study, "Social Factors in Alcoholism Diagnosis," found that physicians, after they had been trained how to diagnose alcoholics, still viewed and diagnosed alcoholism as a disorder occurring primarily in derelicts and failed to identify it in those who did not fit into that category.

Intellectual learning is not necessarily accompanied by emotional acceptance. Our stereotype of the alcoholic does not change until we are

die while we search for the underlying emotional "cause."

comfortable in looking at drinking and drinking problems in a consistent and informed manner.

It is amazing how much information the average professional person is able to gather in his case records about the individual's childhood experiences, parent and child relationships, when he developed an Oedipus complex, and whatever else we may consider meaningful, in spite of the limited time we have in our heavy case loads.

Yet, there is little, if anything, we know about the person's drinking history. Is he a periodic or daily drinker? Has he ever been on the wagon? Does he drink with others or by himself? Does he come from a family in which drinking was the problem?

The patient is already reluctant to discuss his drinking; and we help him along by conveying to him directly or indirectly, that this is not really important, but if we could get at his childhood or whatever we consider meaningful we will really get some place.

One thing is certain, if alcoholism is present it will only become worse —it won't disappear. The patient has a choice to do something about his situation now or later.

We must confront the patient with his behavior, and let him evaluate to what degree his drinking complicates the various problems he presents. Let him make his own diagnosis.

Motivation has been used by professionals as a bugaboo. David J. Pittman, Ph.D., discovered in a recent study that therapists judged the alcoholics to be motivated if treatment was successful, and unmotivated if it was not.

It has been proved that the nature of the therapeutic setting had more effect many times on the recovery rates than the alcoholic's initial motivation.

Compulsory treatment is often effective; and motivation can be created through the right approach and attitudes by the therapist. Certainly if we did not believe in this we would not have any juvenile courts, protective services, or other types of treatment settings where individuals are seen initially on an involuntary basis.

Attempts should be made to convince alcoholics of the need for treatment or rehabilitation.

It has been demonstrated that even those judged to be completely unmotivated and who cannot be reached readily can become involved in treatment through a change in procedures and approaches.

Through such a change at Massachusetts General Hospital in Boston, the alcoholics that were seen for emergency care, and who previously only came in for detoxication, were enabled to follow through on referrals made and actually stayed in treatment over an extended period of time.

We must be ready to see alcoholics when they need help most. Waiting periods are unreasonable for the first contacts. If we ask the patient to come back in a week from now, we are likely to lose him.

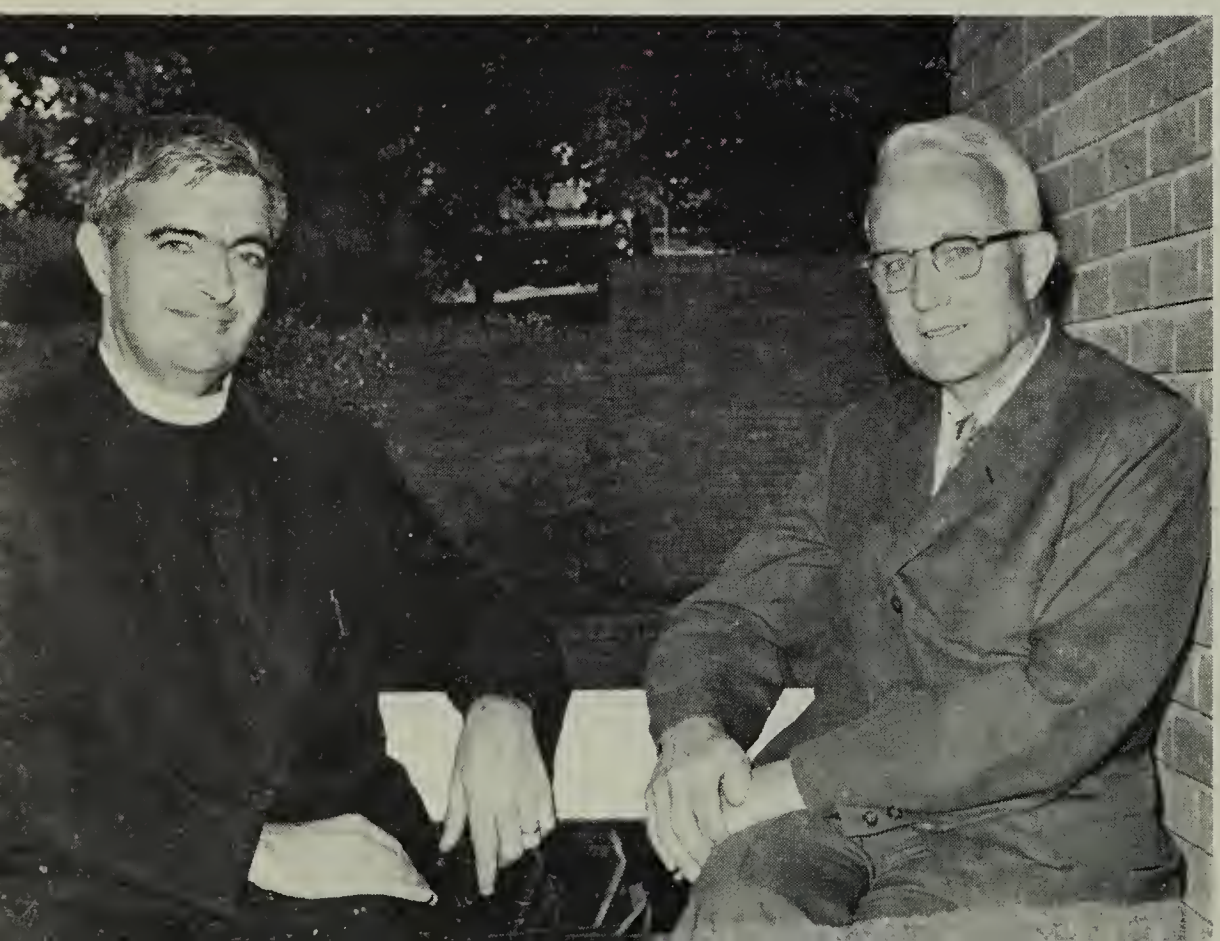
Unrealistic goals deter patients from seeking the help they need. Such goals allow us to eliminate those who need the help most, so that we can concentrate on working only with the ones we are most comfortable with and who meet our needs.

(Continued on page 18)

What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

On the right you will see scenes from the largest group ever to assemble anywhere in the world for the purpose of sharing research and treatment findings in the area of alcohol and alcoholism. The group, the 28th International Congress on Alcohol and Alcoholism, met September 15-20 at the Shoreham Hotel in Washington, D. C. In attendance were 1,671 "citizens of the world" from 32 countries. Over 250 scientific papers were presented at the Congress which explored biochemical, psychological, sociological, economic, legal and law enforcement aspects of the problem.



On the left are H. Middleton Raynal of Sanford and Dr. John L. Norris of Rochester, N. Y., medical director of Eastman Kodak and chairman of the General Service Board of A.A. On Sept. 20, Dr. Norris spoke at a 6 o'clock meeting of the Lee Co. Council on Alcoholism, an 8 o'clock public meeting and breakfasted the next morning with 12 physicians at the hospital. (See related story page 27)


CONGRESS ON ALCOHOL & ALCOHOLISM

It is interesting that in one of our tax-supported hospitals, alcoholics cannot be accepted until they have been sober for two weeks. This is like treating kleptomaniacs for their illness after they have stopped stealing for two years.

There is a need to reduce the alcoholic's tensions and anxieties, but not too much. Once he feels too good he is likely to believe that his problems have been overcome.

An outgoing approach, rather than a passive one, educating him about his illness, setting clear limits, working with him at a time of crisis, when he is more ready to admit his problem—or even creating a crisis, if necessary, and working with his anxieties are some of the ingredients in being helpful to the alcoholic patient.

In an early stage, treatment is simple. The patient may only require information about the symptoms of alcoholism that might enable him either to moderate his drinking or to stop altogether, if indicated.

Industry is able to reach the highest recovery rates, ranging from 60 to 90 percent. Employers can motivate the employee more readily, since they can take away his job and the benefits he has accrued in the company. Industries with a good alcoholism program are more readily able to locate the problem drinker in their midst and direct him to appropriate treatment.

John R. Philp, M. D., has developed a diagnostic approach based on the levels on which the person functions and the rehabilitative services he will require accordingly.

As the individual's social, occupational, and family relationships become disrupted to a greater degree (and physical deterioration may have set in) the greater are his needs for complex services including medical, halfway houses, institutional care, vocational guidance and counseling, and resocialization.

Some persons may have to live in a semi-institution or in some sort of protective care services until they can gradually become more self-reliant and self-supporting through the help we can offer them. They can at least function within the institution adequately and can gradually be integrated into community life once again.

Even if they need to be institutionalized, we can help them at least to function more adequately within the institution to help themselves to the greatest possible degree. In many instances, we can assist them to leave the institution for short periods until they are able to leave permanently.

Help for Family Members

Alcoholism is a family illness, and it affects not only the one who is drinking, but, even more so, the ones who must live with the problem. Family members can be helped, even when the alcoholic refuses to do anything about his situation.

At one time the wife was regarded as a victim of the alcoholic. Later on she was looked upon as the cause for his drinking, who, even if the husband would recover, would go to pieces, since she had a subconscious need for an alcoholic. That is not necessarily so.

The alcoholic usually denies his drinking, trying to prove that he can handle it; and the family tries to get him to recognize the problem and do something about it. They appeal to him, feel sorry for him, become angry, cover up for his behavior, make excuses to their friends, and become as inconsistent and as frantic in their approach as the alcoholic is in his denial and his covering up.

The stigma attached to this illness is so great that the family becomes part of the hiding process.

They feel guilty and believe they must have done something which causes him to drink.

The alcoholic in turn may blame them.

They accept the blame.

They try to find out what not to do, so he won't drink. They look for the reasons for his drinking and try to avoid them.

They are unable to predict from one day to the next what he will be like or what is going to happen. They go through periods of despair, hopelessness, and fear.

The wife appeals to him, to his love, to his concern for the children, the effect on their reputation. She pours the liquor down the drain, or she drinks with him—all this to no avail.

As alcoholism progresses, communication breaks down. They are unable to discuss his drinking, their finances, family affairs, and soon there will be no discussion. Social life becomes disrupted.

At times the wife almost wishes he would kill himself and get it over with; and then she feels guilty about such thoughts. She may finally leave him when she cannot take it anymore, and then comes hurrying back when he shows some temporary improvement or seems to accept the need for help.

She needs to learn that she can accept the person but does not have to accept his behavior. She must learn to become consistent in her approach. She should never threaten unless she intends to carry it out.

Usually all of the family's efforts are directed towards stopping the alcoholic from drinking. They want to protect him and themselves from the consequences of his behavior.

They are often unable to take action, to seek help for fear of his reaction. The longer the delay about facing this illness, which is progressing in their midst, the greater the depression, the greater the loss of confidence in themselves. They steadily drain themselves of their physical and emotional resources to cope with their daily lives.

Drinking may reach the point where the family must try to lead their own lives as much as possible without trying to do anything about the alcoholic's drinking and without attempting to cover up for him, or, if this is not possible, they may have to leave him in order to protect themselves and their children.

Once this separation occurs, reconciliation should not be considered until the alcoholic has received help for a reasonable length of time. The family must shift their concentrated attention from doing something about the alcoholic toward doing something for themselves.

In working with alcoholics and their families, referrals and follow-ups are essential.

We often do not refer when we have a good relationship. We seem to be afraid that someone else will mess it up.

We usually refer at a point when we are so frustrated that we don't know what to do. At this point referral is most detrimental. We may refer to a psychiatrist, indicating that the individual needs a specialist, that we can no longer help him. In this case the psychiatrist is almost approached as a kind of magician who can do things we aren't able to do.

We all recognize the need for a team approach; and then we promptly proceed to work in our own little corner and disregard the other areas

(Continued on page 23)

BY VIRGINIA LONG, A.C.S.W.
ASSISTANT PROFESSOR
UNIVERSITY OF NORTH CAROLINA
SCHOOL OF MEDICINE
CHAPEL HILL, N. C.

What the FAMILY Can DO While the PATIENT Is Away

IT is not unusual in the lives of alcoholics and their families for the alcoholic to be away from the family. Sometimes he is hospitalized for treatment of an acute illness caused by drinking. Sometimes he voluntarily and soberly enters a rehabilitation center. Sometimes he is sentenced to prison. What are the family's reactions and what can be done during this separation?

Usually entrance into an institution is the outcome of a drastic drinking episode with all the accompanying violence, physical illness, and emotional turmoil. Frequently the family is exhausted. There were nights of sleeplessness and fear. There was sacrifice including financial sacrifice. Family members were filled with pity and contempt as they saw husband and father groveling with his problem. They were courageous as they went to school and walked the streets of the community, heads held high, attempting to hide the family's shame and embarrassment.

What can a family do while the alcoholic is away? Perhaps the first action should be one of self-comfort. Perhaps licking some wounds, figuratively speaking, is in order; rest, doing some things that were not dared for fear of upset. If at all possible the children should have some things they've needed, and for mother, perhaps a trip to the beauty parlor. Some favoritie meals and relaxation are in order too.

After a period of recuperation, everyone can begin to think—good thoughts as well as bad. Perhaps it's easier still in this first stage to think of the anger, the bitterness, the disappointment, and the fear. The whole family should talk together about these feelings, not just the mother and the oldest son, or the mother and the oldest daughter. The worries should be passed around so that everyone can express feelings because they are there, and there are usually few secrets in families. As the ugly feelings are talked about, then the good feelings come forth too. One may remember the things the alcoholic tried to do, the frustrations and failures he felt, the high ambitions he had. (Most alcoholics want things nice, they try for good things, they want the best. For example, many alcoholics have the prettiest wives.)

The next action takes a hundred times more bravery and courage than most people think they have, and much more courage than already shown as the family worked

The family needs to learn what kind of problems the drinking is hiding and how the resulting distress can be met without resort to alcohol.

to keep a lifeline anchored to normal living during the tumultuous days. This next activity is to look at one another, every member of the family, to see how this family acts towards each other. Dr. Theodore Lidz, in describing his treatment of psychiatric patients at the Yale Psychiatric Institute, said that his staff never discharged a patient until there was change in the emotional give and take among all the family group.

Mustering all possible courage, the family should look at what are some of the ways they get along. Have they tried to keep the alcoholic from drinking? Perhaps hidden his whiskey bottle? Have they saved money on groceries in order to buy school books so he wouldn't be worried about extra demands as school begins? Has mother **not** pushed him to take her to parties where he might be uncomfortable unless he drinks? Has she not tried to leave off fussing when he came home late at night, even when she wondered where he was and what he was doing?

Many families say "yes" to all these questions. At the same time both people and journal articles place blame on the wife and the family of the alcoholic. Let's get it straight before we go on that no one thinks the family is **deliberately** resisting or sabotaging the alcoholic's efforts to stop drinking. The family is "no more 'to blame' than the compulsive alcoholic who knows what will happen if he has that 'one too many' but has it anyway," as one **Cosmopolitan** writer expressed it. The family of an alcoholic, no matter what neurotic gains are achieved by the drinking, suffers great and continued anguish as a result. Nevertheless, leaving blame aside, can a family look at what is happening? Can a wife, a son, or a daughter see if there is also some "deep down" reason that she or he may **want** the alcoholic to drink? Can one have the courage to accept one's own devious and hidden needs? This really takes courage.

Nellie Jones courageously looked at her family situation and unravelled this mixup after she came to the psychiatric clinic because she stayed scared all the time that she was going to drop dead. She complained of many things but mostly her husband's drinking sprees. She blamed these sprees on her husband's derelict cousin, Joe, who stayed drunk most of the time. She began to see that she encouraged derelict Joe to hang around their house so that in case she dropped dead she'd have someone with her. At the clinic Nellie confessed her own "sins" about her teen-age sexual experiences. She feared she'd confess also to her husband who would then surely strike her dead. When her husband was drunk, he was too preoccupied with his drinking to listen to her. She began to see that nobody should strike her dead for things she did fifteen years ago when she was still a child. Then she was really able to tell old Joe off, and send him on his way, and therefore get rid of her husband's drinking companion. With Joe gone and the household more relaxed, her husband didn't need to drink.

Sometimes the family's need for the drinking can be understood better by the alcoholic. Mr. Blake, an

alcoholic, mustered up his courage to try something different. He almost lost an excellent job and therefore decided to quit drinking. Then he almost lost his wife. Mrs. Blake, the middle daughter, unwanted and unloved, obtained real comfort from her neighbors, her minister, and her husband's employers. They knew what she had put up with, silently and courageously, as her husband drank. They knew how she shielded him from the public and waited on him when he was drunk and demanding. She always looked neat, immaculate, even though half an hour before she'd been down on hands and knees cleaning up vomit. Nevertheless, when her husband was threatened by loss of a job he definitely quit drinking and his wife, on the verge of insanity, kept chattering constantly that she was going to leave him. While she was hospitalized the husband took a look at what losses occurred for his wife on account of **his sobriety.** No one flattered Mrs. Blake on what she did. No one respected her courage and patience. She was taken for granted. She had a nice husband with a good job. Mr. Blake solved this dilemma by becoming more demanding, more dependent while he was sober. The community responded. They appreciated what his wife was doing to help him to stay sober, and things were back in balance.

What is your family balance and can you handle it with a sober husband and father? Mary Mally of the Outpatient Alcohol Clinic, St. Francis Hospital and Rehabilitation Center, Pittsburgh, Pennsylvania, in her unpublished study of family patterns of thirty alcoholic marriages, states that it became evident that the symptom of alcohol was made the focal point, and that the alcoholic family patterns were turbulent but well organized to keep the focus on alcohol in order to keep from looking at other problems. If the father gives up drinking, a child might start failing at school in order to upset the family and start the drinking again. In Miss Mally's study, as the husbands sobered up one wife became involved with a "beat" group and was on the verge of having an affair, two wives began eating excessively, one wife began to drink to calm her nerves, and another took a night job as a waitress in a bar-restaurant where drinking was constant. As these wives began to act up, the patients, still sober, began to show anxiety by unusual behavior. Some patients withdrew to their rooms afraid to come out and others had anxiety attacks. Still others took medicine, became overzealous about religion, and clung to other people.

Underlying Family Problems

What are the family problems covered up by the emphasis on the drinking? Each family needs to solve this riddle. Some generalizations have been made. Usually families have a generational history of drinking. Frequently the wife's father drank. Alcohol and the reactions to alcohol are old acquaintances, an ingrained way of dealing with problems. Many times realities that need to be faced are that the husband and father is an angry, withholding man who expects to be taken care of. The wife and mother is disappointed and angry, both at the dependent demands of her husband and the frustrations because her own dependency can't be met. The alcoholic sprees are the setting for venting of fury as well as dependency. When the sprees are

no longer present, other targets are found, thus upsetting the usual family balance. Sometimes an older child becomes the focus of the anger. The family usually decides drinking is the least of the possible evils.

During group therapy a wife described her concern in terms of a new car. She spent an hour talking to the other ladies in the group about the new car that almost drove itself, that never went in a ditch, was "trustworthy." If anything happened to the new car the neighbors would blame her poor driving, her stupidity, whereas the neighbors before had bragged about her excellent driving, how she handled such a difficult car no one else could drive. As she talked the other ladies in the group knew that her husband had been sober for two weeks, a longer period of time than for many months, and they could see that she was talking about both the new car and the "new" husband.

The family, therefore, needs to take a good look. What are they doing? Sometimes the family can ferret this out, but usually professional help is necessary. A family needs to know the available community agencies. Is there a psychiatric clinic, an Al-Anon and Alateen Group, a family service agency? In these agencies, a family can find individual treatment and group treatment to learn what kind of family ills the drinking is alleviating; of what family ailments the turmoil and the suffering are expressions. The family then can be helped to see how the needs which result in this family distress can be met positively, without the resort to alcohol. This takes courage, real effort; the stakes are high; and the rewards can be great.

THE HELPING PROFESSIONS

(CONTINUED FROM PAGE 19)

of the person's lives and needs.

First we must be as helpful as we can, and refer at a point when we have a good relationship with the patient. We should recognize that we cannot always do the whole job ourselves, that the person needs help in several areas, medical, personal, and family relationships, vocational readjustment, et al.

We have to combine our efforts with those of others: the ministers, the social workers, and other agencies who can provide the necessary services the individual requires. In this manner we are able to attain successful recovery for the patient and his family.

We often suggest to patients, that they attend Alcoholics Anonymous. How many of us have been to meetings and know how it works? It is like saying to a patient, "Go to the hospital, I don't know what the hell they are doing over there, I've never been there myself, but it's good for you."

We should be greatly surprised in these instances if referrals work out. The patient must know why he is being referred, must accept the need for referral, know what he can expect when he goes there. He must know that he can return to us for further help.

As we maintain a helpful relationship, we can enable him to accept a constructive referral, otherwise we only further his feeling of rejection and hopelessness.

The alcoholic can recover if we help him to take advantage of the various resources, both lay and professional in our community, along with the understanding and help and concern which we can provide to him in time of need.

For Health Education Class

Would you please add my name to your mailing list to receive *Inventory?* I would like to use it in my health education class.

Don Maphis, Assistant Chairman
Physical Education Department
Catawba College
Salisbury, N. C.

Self-Help Aid

I appreciate the Jan.-March issue of *Inventory* you sent me and also the back issues. I have learned quite a bit about myself and how I can help myself by reading them. I will be leaving here this summer, but I will send you my new address. Thank you.

Anonymous Inmate
Department of Corrections
Newland, N. C.

Helpful to Nurses

We find your journal on alcohol and alcoholism most helpful to the nursing personnel caring for the alcoholic patient. I would appreciate it if you would place my name on your mailing list.

Mrs. Mary Ellen G. Lutz
Associate Chief, Nursing Service
for Education
Veterans Administration Hospital
Oteen, N. C.

He Helps In Rehabilitation

I am working with the alcoholic rehabilitation program in the City of Durham, and would like to receive *Inventory.* Thank you.

Anonymous
Durham, N. C.

South Africa Clinic

A copy of your magazine, *Inventory,* which we receive regularly, is circulated amongst our Head Office professional staff who find it very valuable and interesting.

Seeing that it will also be of value to the professional staff of our clinic, I will appreciate it very much indeed if you can favour us with two additional copies.

J. B. Higgins, Secretary
Temperance Union
Kempton Park, South Africa

Interests Caseworker

I am a caseworker with the local welfare department and am very interested in alcoholism. Would you please place my name on the mailing list for future copies of *Inventory?*

Mrs. Melita G. Moore
Morganton, N. C.

Writes About Prevention

Your article "Early Detection of Alcoholism" by Michael Thomas Mennuti should be in the hands of every person interested in helping persons who may be problem drinkers.

I have read countless articles on alcoholism but this is the first to approach the young people in determining if they may be future alcoholics. "An ounce of prevention is worth a pound of cure."

James Jones
Senior Probation Officer & Work
Release Coordinator
Municipal Court
Minneapolis, Minnesota

From a Woman's Point of View—

Thoughts On The Woman Alcoholic

BY JEAN MOSIER
COUNSELOR
FLORIDA ALCOHOLIC REHABILITATION PROGRAM

The female alcoholic is a woman, and this in itself is a problem for her.

Reprinted from *Insight*, published by the Florida Alcoholic Rehabilitation Program.

FOR quite some time now I've wanted to try to put into words my feelings and thoughts about the very special phenomenon—the woman alcoholic.

This is not backed up with scientific facts or statistics, but rather my own experiences and observations.

I have met and known and worked with nearly every woman patient who has been admitted to Florida Alcoholic Rehabilitation Center at Avon Park. For the past six years I've had an open-ended women's group. I've talked with them on the phone at one or four o'clock in the morning . . . on Christmas Eve . . . or the Fourth of July . . . on a rainy day . . . on a birthday or on an anniversary . . . and so on.

What is she like. Let me try to describe her. She can be a housewife or a teen-ager. She's a grandmother or a career woman. She's a waitress or a tuberculosis patient. She's all of these or more—or she's none of these. She's a woman and that in itself is a problem for her.

She doesn't feel her femininity by the time I see her. She feels frustrated and inadequate and unlovable. She's lonely and depressed and anxious. If she still has a family—husband and children—she is feeling unloved and insecure. And probably, her family is truly sick and tired of her and her pitiful efforts to control them.

The woman alcoholic is no longer an enigma. She is very much a part of our culture today. The luxury of being hidden has been taken away from her. Society is forcing her to come out and make some choices about herslef. Is she going to try to continue to control her family with her fear tactics like their reasons for caring may be—threatening suicide or running away? Is she going to face her responsibilities or stay intoxicated in her bedroom? Is she going to recognize and distinguish between her feelings of anger towards herself and others? Does she want to gain an understanding of her behavior?

She seeks help for many reasons, of course, but among these nearly always is the fact that those who care whatever manage to get across an "either or" situation to her; that is, either get help or get out. She makes her choice; then we see her.

Interpersonal problems can be resolved, not just endured. She cannot be separated from her past and present behavior, but she can be helped to change that behavior.

When she seeks treatment for her alcoholism it is the beginning of her ability to risk herself and it's a turning point for her. That is, instead of saying "I don't know" or maintaining silence or withdrawing altogether, she will now have to verbalize what she is thinking and feeling. She will have to try to communicate with other human beings.

In the urban societies today the family is being forced into isolation. People don't seem to care about one another. The woman who becomes alcoholic is without a doubt the loneliest of people and the most bored. When alcoholism shows itself in the chronic phase she is probably around the age of 45. This, incidentally or coincidentally, is also the approximate age when her children no longer seem to need her or love her. They are gone, and she feels rejected and so alone.

Also, her husband as a male is at the peak level of his achievement. He has and is making his mark in his world; it has been and is competitive, exciting, and interesting to him. Along the way she has been left out—whether emotionally or realistically—so she in turn has become more and more involved in her alcoholism.

Her solution to her dreadful feelings has been simply drinking more and withdrawing more.

Who else is she? She's the prostitute who has grown too old to be interesting. She's having to face the fearful reality of it and can't.

She's the secretary who has become older and is no longer the once-pretty thing (experience isn't everything).

She's the business woman who can't make the change to modern thinking and methods.

She's the school teacher who can't fall back on the way it used to be because education has become so progressive.

She's the teen-ager who has had an emotionally deprived childhood and thus hasn't the emotional stamina to even begin facing the realities of life.

Why can't she change? It's so much easier not to change. To change is to threaten. She doesn't want to get involved in the unknown. She's a dependent person who struggles with the dilemma of self-assertiveness and aggression. She can get intoxicated and express herself in language any sailor could command. But it's terrifying to sober up and look at what she's said or done.

The anger is bound up within her. It comes out in elusive ways for many of us, but for the woman alcoholic her feelings of anger are so threatening that the way most successful and least painful for her is to let them explode with the help of alcohol. Her anger is destructive and terrifying, but she dare not admit it.

She "Missed the Point"

What about her treatment. I often think about the woman alcoholic patient who, after she returned home, became quite angry. In a torrent of angry activity she ripped down the drapes, broke the dishes, turned over the furniture, and slashed the clothes. When she had finally given vent to her feelings she turned in triumph to her astonished family members and said, "There! That's what I learned at Avon Park!"

Aside from the various innuendoes which I could discuss, I would state briefly and perhaps naively that she "missed the point." One of the things she didn't comprehend is

the most important fact that all of us get stuck with the responsibility of our behavior. Responsibility becomes an enormous factor.

The woman alcoholic must begin to distinguish between how she thinks and how she feels, because there is a great deal of difference. She wants to be loved, but she is fearful of the responsibility of a love relationship. She is an emotionally dependent person and feels she cannot cope with things. She must deal with these various feelings rather than deny them.

In my women's group on July 15, 1968, we discussed the woman alcoholic. I asked them to describe her. I'm including the words they used. It's a long, descriptive list, but so meaningful when you hear these words from the lips of a woman alcoholic:

F r u s t r a t e d, inadequate, depressed, lonely, emotionally upset, bored, immature, indecisive, unstable, undesirable, anxious, fearful, restless, untidy, selfish, indifferent, unloved, unreliable, inferior, unpredictable, hateful, sneaky, uncooperative, liar, sly, cheat, promiscuous, hypochondriac, impotent (?), hostile, dangerous, irresponsible, repulsive.

After we compiled this list and the group members were obviously uneasy at facing themselves, I told them I was thinking about writing an article about the woman alcoholic—or, should it be the "female" alcoholic?

Many expressed the opinion that "female" was a better choice. After much discussion I gently reminded them that there are numerous female species, but only woman and her femininity is a human being.

As we've said, the female alcoholic is a woman, and this in itself is a problem for her.

ALCOHOLISM 'EMERGENCY'

BY HENRY BLUMENTHAL
CITY EDITOR
THE SANFORD HERALD

A self-described "honorary alcoholic," an international expert on alcoholism who's proud of his "honor" although he's not alcoholic for real, told a Sanford audience Friday night:

"If anything else in the U. S. created as much tragedy, as many deaths, as does alcoholism, it would already have been declared a national emergency."

These were the words of Dr. John L. Norris, a one-time general practitioner who is now recognized as a world authority on alcoholism, invited to Sanford by the Lee County Council on Alcoholism.

Dr. Norris, fresh from playing a leading role in the 28th International Congress on Alcohol and Alcoholism in Washington, spoke at a meeting of the Council at Campbell's Restaurant and later at the Elk's Club to a public audience.

He said he began attending Alcoholics Anonymous meetings after an experience he had with an acquaintance . . . because up till then he felt he was failing in his treatment of patients with alcoholism.

Now chairman of the General Service Board of A.A., he said he has learned that "sometimes people get drunk at the next party after they've told themselves and others, with sincerity, that they wouldn't. That's when they realize their problem.

"The earlier we can get to people, the better we can help them. We can't wait and then pick up the pieces."

He described the horrible experiences an alcoholic can have before he finally levels with himself that he is in trouble—and how such experiences can be avoided if the symptoms (as with any physical disease) are recognized early enough.

He berated the "reluctance of society to look realistically at problems alcohol is causing," that "it is considered too casually . . . as indifferently as the alcoholic himself sees his own problem at first."

"If we can develop modes and customs in our society to promote respect by those who don't use it (alcohol) by those who do, we will have gone a long way toward licking the problem." (Excerpt from *The Sanford Herald,* Sanford, N. C.)

THE ROLE OF A SOCIAL AGENCY IN THE CONTROL OF ALCOHOLISM

BY JANE LATHAM

"The point is that we must somehow identify our own role in the helping process, intervene when appropriate, and leave the field to others when this is indicated."

Miss Jane Latham of New Bern, N. C. is the senior child welfare caseworker of the Craven County Department of Public Welfare. This article is based on her contribution to a symposium on "Community Helping Agents" during the 1968 Summer School of Alcohol Studies at the University of North Carolina.

WE in Public Welfare were among the early pioneers in the effort to promote the cause of alcoholism treatment and prevention. We were among the first social agencies to recognize the dramatic effects on family stability brought on by alcoholism. We recognized at the same time, the futility of isolating the ill member in an effort to inject a miracle treatment technique which would bring him once again to health. Although we did not design this effort as such, it was thrust upon us and, as in many such social ills, we saw immediately the need for a community approach—even to an individual problem. We saw this need because the nature of alcoholism is such that it thrusts itself upon you, crying for help, not wanting help, and showing its many faces in well-established defenses, too many for any one group of therapists to handle or any one agency to solve.

Although somewhat melodramatic in its implications, I do not believe I have overplayed alcoholism as it is brought to bear on the life of the community. Departing from the focus at this point, I suggest that any emotional illness might affect families, communities in the same way. You can almost substitute the phrase "emotional ills" for alcoholism in much of what I have said.

A change in view, over a period of about twenty years, has and is emerg-

ing in Public Welfare in agency responsibiltiy, in prevention and in alcoholism.

First, in agency responsibility, the public welfare agency in most counties in North Carolina is the only family-centered agency in the community. This means that in the treatment of the family, we help in identifying individual roles within the family such as who lines up with whom — parents against children, mother and children against drinking father, etc. In doing this we help the individual family members seek new ways of attaining greater satisfaction and more comfortable interpersonal relationships. We deal with problems of psychic discomfort, how to bring up children, and many others.

This focus recognizes that we live in families; that any help sought and given is of little value unless it can be integrated into the group significantly close to the troubled person. So we treat families.

The idea of treating families is not new, but we who identify at times so closely with the sick member have failed to realize our responsibility to those closest to him. It is certainly true that families contribute to our problems but, by the same token, they lend support in solving them. Alcoholism, we have come to believe, is a symptom, a distorted way of assuring a more comfortable existence. It stands to reason, therefore, that better understanding by those closest to him opens the way to provide a different and more acceptable means of dealing with the same old problem, that will need solving over and over again, even after the alcohol is gone.

I do not mean to sound discouraging, but I submit to you the idea that *family* treatment is necessary to help in the recovery of alcoholism. And we must never forget that in a real sense chances of recovery are far greater when the family becomes its own "therapist." The social worker can serve as something of a catalyst, little more.

In prevention, although a separate subject, we talk in the same vein as before because we are social beings born into families and communities which are influencing each other. Knowing that parent-child relationships influence the stability of families and individual members, it becomes our obligation to teach certain pertinent facts within the framework of our profession. Let me give you a case in point:

Recently I have been seeing for counseling a woman in her early thirties who came in initially to discuss the problems of her adolescent daughter. She was quite reluctant to discuss family relationships, including a very poor relationship with her own husband who in turn had poor relationships with his children. As the counseling developed and continued, she began to understand that in order to talk about one member of the family and that person's problems, it is necessary to involve all of the other members at least in a discussion of family relationships.

Teaching mental health values, helping identify problem areas, steering the client to other professional help and being able to recognize when this is indicated are all pertinent to our work. Part of our orientation with new social workers is a session on, and a visit to, the Alcohol Information Center because it is an important resource in helping to prevent further family breakdown, and will provide, simply for the asking, a mammoth amount of information and well-documented research reports.

The third (but not because it is

least important) emerging change as I see it is that the needs of the acutely ill alcoholic are being met in the community more and more adequately. For one thing, his symptoms demand attention and every social agency should have policies covering the needs of this group just as much as the heart attack patient, the tuberculosis patient or some of these so-called more "acceptable" illnesses. Fortunately, our hospitals are beginning to accept alcoholic patients for emergency treatment. It is, therefore, incumbent upon the appropriating bodies to assure the same service and payment for alcoholism as these other illnesses. Through the good work of the alcoholism education groups in our communities, this is beginning to come about. And, of course, we must feed the family while the breadwinner is being treated. As heavily restricted as I know we are in the spending of money, a denial of assistance because there is no money, simply should not be. There are adequate resources for this kind of thing somewhere. If I may be mildly critical of us, I fear we impose our own biases at times on those whom we should serve.

Now, what about coordination of help within the community? There are certain aspects of the alcoholic's illness (and indeed any emotional illness) of whch there is no question as to whose responsibility treatment is. Delirium tremens, serious medical conditions such as liver involvement and malnutrition from years of inadequate nutrition and excessive drinking are matters for the medical doctor. Many times the hospital is the only place for this treatment. Therefore, it takes a coordinated effort to see that these initial problems are dealt with. Then, two things sometimes happen which set the stage for further coordinated effort: The alcoholic is lifted out of the drinking cycle (at least temporarily) and the family gets some rest.

When this set of circumstances presents itself, we should ask who is the most significant person in the lives of the family? It may be the minister. If this is so, I would hope that the counselor or helping person would call him in. But it may be a caseworker, and especially if the family has been in need of financial assistance during this time. The point is that we must somehow identify our own role in the helping process, intervene when appropriate, and leave the field to others when this is indicated.

In our agency, we have been trying very hard for several years to use anyone (law enforcement, public health, minister, all the others) who has demonstrated a degree of success in working with some of these families. The coordination of effort must include a willingness to allow other agencies and persons to help as well as assume our responsibility when this is indicated.

Working With Others

The public welfare agency, beyond its legal responsibility to meet financial need and, at the same time, offer casework services in the helping process, sees as part of its role the discovering of significant agencies and persons who may very well do the job in individual situations better than we. We must not jealously guard our knowledge of alcoholism and pretend that we have the only key to success in counseling in this area.

Together, our mutual goals—the goals of concerned agencies and individuals—can be accomplished if we are willing to decide what our individual roles will be in this difficult business of helping.

(CONTINUED FROM PAGE 12)

major health problem there must be more vigorous leadership shown at the federal level. Current efforts by Washington to cope with alcoholism are fragmentary and do not represent a national attack on alcoholism.

Last year the Federal Government spent only 11 million dollars on alcoholism control—the cost of two Boeing 707 aircraft—while taking in some 4 billion dollars in alcohol tax revenue. This miserly expenditure of funds on a national problem of great importance occurred despite the fact that over one-third of the arrests in America are for public intoxication, despite the fact that 40 to 50 per cent of all fatal traffic accidents involve chronic alcoholics or heavy drinkers, despite the fact that 40 per cent of residual tuberculosis cases are alcoholics, and despite the fact that hundreds of Americans die needlessly in jail cells from the effects of chronic alcoholism.

It is time to re-examine our priorities in America and to mount systematic and far-reaching programs to combat the critical domestic problems which confront us, such as alcoholism, poverty, and and water pollution, and crime control, before sinking all of our treasures into questionable foreign ventures.

Currently, the Congress has before it Senate Bill 1503—the Alcoholism Care and Control Bill of 1967—with bipartisan sponsorship from Senators Javits of New York and Moss of Utah, who were joined by 36 other Senate colleagues in April, 1967, in introducing this legislation. Briefly, this legislation would establish a Bureau of Alcoholism Care and Control to coordinate and direct Federal Alcoholism Programs.

The bill strongly emphasizes detoxification centers under medical supervision, treatment centers for patients under court order, treatment programs for alcoholics in jail or correctional institutions, and aftercare or post-institutional programs for alcoholics. Immediate enactment of this bill by the Congress of the United States would go a long way in rearranging national priorities and help in the solving of the alcoholism problem at the state and local level.

The Congress also has before it HR 15758, introduced for the Johnson Administration by Representative Staggers of West Virginia. House Committee hearings on this Bill were held in late March, 1968. This Bill calls for construction grants as well as staffing, operation, and maintenance grants for new alcoholism facilities in conjunction with community mental health centers. Unfortunately, it is not as far-reaching in scope and programs as the Javits-Moss Bill previously discussed.

Conclusion

In conclusion, the last few years have seen a growing political and community awareness of the problems of alcoholism. We are on the threshold of a major breakthrough with a legislatively enacted alcoholism control measure at the federal level. It is my fervent hope as Chairman of the 28th International Congress on Alcohol and Alcoholsm, which meets for the first time in the United States since 1920 this September, that this event will be one at which this victory of legislation may be celebrated. If so, it will be because of the dedication and the hard work of the state and municipal alcoholism programs, and the agencies and individual members of the North American Association of Alcoholism Programs, and the National Council on Alcoholism.

DIRECTORY OF OUTPATIENT FACILITIES BY COUNTY —for ALCOHOLICS and/or THEIR FAMILIES

Key to Facilities

+ Community Alcoholism Program
(supported jointly by the community and the N. C. Department of Mental Health)

*** Community Alcoholism Program**
(supported largely by funds from local boards of alcoholic beverage control)

‡ Joint Mental Health and Alcoholism Facility
(supported by the community and the N. C. Department of Mental Health)

† Mental Health Facility
(supported by the community and the N. C. Department of Mental Health whose services are available to alcoholics and their families)

Competent Help Is Available At The Local Level

ALAMANCE—

+ *Alamance County Council on Alcoholism,* Room 802, N. C. National Bank Bldg., Burlington 27215; Tel: 919-226-4403.

† *Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd., Burlington 27215, Tel: 919-227-6271.

ALLEGHANY (See Watauga)

ANSON—

† *Anson County Health Department,* Wadesboro 28170, Tel: 704-694-2516.

* *Education Division, Board of Alcohol Control,* 125 Wade St., P. O. Box 29, Wadesboro 28170, Tel: 704-694-2711.

AVERY (See Watauga)

BERTIE (Hertford, Martin)—

+ *Roanoke-Chowan Alcohol Information and Service Center,* 111 Belmont St., P. O. Box 143, Windsor 27983, Tel: 919-794-2895.

BUNCOMBE—

+ *Alcohol Information Center,* Parkway Offices, Asheville 28802, Tel: 704-252-8748.

† *Mental Health Center of Buncombe County,* 415 City Hall, Asheville 28801, Tel: 704-254-2311.

BURKE—

* *Burke County Council on Alcoholism,* 211 N. Sterling St., Morganton 28655; Tel: 704-443-1221.

CARTERET (See Craven)

CABARRUS—

† *Cabarrus County Mental Health Clinic,* 102 Church St., Concord 28025; Tel: 704-786-1181.

CATAWBA—

* *Catawba County Council on Alcoholism,* 420 Seventh Ave., S. W., Hickory 28601; Tel: 704-328-3564.

CLEVELAND—

† *Cleveland County Mental Health Clinic,* 101 Brookhill Rd., Shelby 28150; Tel: 704-482-3801.

CRAVEN (Carteret, Jones, Pamlico)—

‡ *Neuse Mental Health and Alcoholism Center* (Craven County Hospital, New Bern 28560; Tel: 919-638-5173, Ext. 294)

+ *Division on Alcoholism,* 411 Craven St., P. O. Box 1466, New Bern 28560; Tel: 919-637-5719.

+ *Division on Alcoholism,* 506 Broad St., P. O. Box 82, Beaufort 28516; Tel: 919-728-4033.

CUMBERLAND—

† *Cumberland County Mental Health Center*:

+ *Division on Alcoholism,* Cape Fear Valley Hospital, Fayetteville 28302; Tel: 919-484-8123.

DARE (See Pasquotank)

DURHAM—

† *Department of Psychiatry,* Duke University Medical Center, Durham 27706; Tel: 919-684-8111, Ext. 3416.

* *Durham Council on Alcoholism,* 602 Snow Bldg., Durham 27702; Tel: 919-682-5227.

EDGECOMBE (Nash)—

† *Edgecombe-Nash Mental Health Clinic*

+ *Division on Alcoholism,* 228 Hammond St., Rocky Mount 27801; Tel: 919-442-8021.

FORSYTH—

† *Department of Psychiatry, Bowman Gray School of Medicine,* N .C. Baptist Hospital, Winston-Salem 27103; Tel: 919-725-7261.

† *Forsyth County Department of Mental Health*:

+ *Alcoholism Program of Forsyth County,* 802 O'Hanlon Bldg.. 105 W. 4th St., Winston-Salem 27101; Tel: 919-725-5359.

† *Forsyth County Mental Health Unit,* 1020 E. 7th St., Winston-Salem 27101; Tel: 919-722-0364.

GASTON—

† *Gaston County Mental Health Clinic,* 318 South St., Gastonia 28052; Tel: 704-864-8381.

GUILFORD—

* *Alcohol Education Center,* P. O. Box 348, Jamestown 27282; Tel: 919-454-2794.

Family Service Agency, 1301 N. Elm St., Greensboro 27401; Tel: 919-273-0523.

Family Service of High Point, 113 Gatewood Ave., High Point 27260; Tel: 919-883-1709 or 919-833-2119.

+ *Greensboro Council on Alcoholism,* 216 W. Market St., 206 Irvin Arcade, Greensboro 27401; Tel: 919-275-6471.

† *Guilford County Mental Health Center,* 300 E. Northwood St., Greensboro 27401; Tel: 919-273-8281.

† *Guilford County Mental Health Center,* 942 Montlieu Ave., High Point 27262; Tel: 919-888-9929.

HARNETT (See Lee)

HENDERSON—

* *Alcohol Information Center,* 2nd floor, City Hall, P. O. Box 472, Hendersonville 28739; Tel: 704-692-8118.

† *Henderson County Mental Health Clinic,* 820 Fleming St., Hendersonville 28739; Tel: 704-692-2138.

HERTFORD (See Bertie)

HOKE (See Moore)

JONES (See Craven)

LEE—

† Lee-Harnett Mental Health Clinic:

+ *Division on Alcoholism,* 106 W. Main St., P. O. Box 2428, Sanford 27330; Tel: 919-755-4129 or 919-755-4130.

MARTIN (See Bertie)

MECKLENBURG—

* *Charlotte Council on Alcoholism,* 1125 E. Morehead St., Charlotte 28204; Tel: 704-375-5521.

† *Mecklenburg County Mental Health Center,* 316 E. Morehead St., Charlotte 28202; Tel: 704-334-2834.

MONTGOMERY (See Moore)

MOORE—

* *Moore County Alcoholism Program,* P. O. Box 1098, Southern Pines 28387; Tel: 919-692-6631.

† *Sandhills Mental Health Center* (Hoke, Moore, Richmond, Montgomery), Medical Center Building, Pinehurst 28374; Tel: 919-295-6851.

NASH (See Edgecombe)

NEW HANOVER—

* *New Hanover County Council on Alcoholism,* 211 N. Second St., P O. Box 1435, Wilmington 28401; Tel: 919-763-7732.

† *Southeastern Mental Health Center,* 920 S. 17th St., Wilmington 28401; Tel: 919-763-7342.

ORANGE—

† *Alcoholism Clinic of the Psychiatric Out-Patient Service, N. C. Memorial Hospital,* Chapel Hill 27514; Tel: 919-942-4131, Ext. 336.

* *Orange County Council on Alcoholism,* Box 277, Carrboro 27510; Tel: 919-942-1089 or (if no answer) 919-942-1930.

PAMLICO (See Craven)

PASQUOTANK (Camden, Chowan, Dare, Perquimans)—

‡ *Mental Health and Alcoholism Authority:*

+ *Division on Alcoholism,* P. O. Box 645, Medical Bldg., Elizabeth City 27909; Tel: 919-335-1663.

PITT—

† *Coastal Plain Mental Health Center,* 1827 W. Sixth St., Greenville 27834; Tel: 919-752-7151.

+ *Pitt County Alcohol Information and Service Center,* 907 Forbes St., P. O. Box 2371, Greenville 27834; Tel: 919-758-4321.

RICHMOND (See Moore)

ROWAN—

* *Educational Division, Rowan County ABC Board,* P. O. Box 114, Salisbury 28144; Tel: 704-633-1641.

† *Rowan County Mental Health Clinic,* Community Bldg., Main and Council Sts., Salisbury 28144; Tel: 704-633-3616.

SCOTLAND—

† *Scotland County Mental Health Clinic,* 1304 Biggs St., Laurinburg 28352; Tel: 919-276-7360.

VANCE—

† *Vance County Mental Health Clinic,* County Home Rd., Henderson 27536; Tel: 919-492-1176 or 919-438-4813.

* *Vance County Program on Alcoholism,* 158 Bypass W., P. O. Box 1174, Henderson 27536; Tel: 919-438-3274 or 919-483-4702.

WAKE—

† *Mental Health Center of Wake County,* Wake Memorial Hospital, Raleigh 27610; Tel: 919-834-6484.

* *Wake County Health Department,* 3010 New Bern Ave., Raleigh 27610; Tel: 919-833-1655.

WATAUGA (Alleghany, Avery, Wilkes)—

† *New River Mental Health Center:*

+ *Division on Alcoholism,* 210 W. King St., Boone 28607; Tel: 704-264-8759.

+ *Division on Alcoholism,* 101-A W. Main St., Wilkesboro 28697; Tel: 919-838-3551.

WILSON—

Aftercare Clinic, Encas Rural Station, Wilson 27893; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.; Tel: 919-237-2239.

* *Wilson County Council on Alcoholism,* Room 308, 116 S. Goldsboro St., Wilson 27893; Tel: 919-237-0585.

Wilson Mental Health Clinic, Encas Rural Station, Wilson 27893; Tel: 919-237-2239.

WILKES (See Watauga)

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INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

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The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

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